PROPOSAL FOR A SECTION 1915(b) CAPITATED WAIVER PROGRAM

SECTION A. GENERAL IMPACT

I. BACKGROUND

Medicaid is a primary source of health care for persons living with the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS). Florida has historically promoted special programs for Medicaid beneficiaries with HIV/AIDS. The State has operated a home and community based services waiver program, Project AIDS Care, since the early 1990's. Through the provision of case management and enhanced services, the waiver program has proven effective in reducing costs for beneficiaries who would otherwise require the level of care in a hospital or nursing facility. Over the past two years, the State has developed a Medicaid disease management initiative for persons with HIV/AIDS. This initiative operates in conjunction with Florida Medicaid's primary care case management program, MediPass. Disease management of HIV/AIDS has demonstrated significant opportunities to improve care while containing health care costs.

Building on these efforts, the 2000 Florida Legislature authorized the Agency for Health Care Administration (the Agency) to develop and implement specialty prepaid health plans to provide Medicaid services to beneficiaries living with HIV/AIDS. The Agency was directed to apply for any waivers of federal Medicaid regulations necessary to establish such plans. The Agency is Florida's single State Medicaid agency. As such, the agency is requesting authority from the Health Care Financing Administration for applicable federal waivers which may be required to implement the program outlined in this proposal.

II. GENERAL DESCRIPTION OF THE WAIVER PROGRAM

A. **The State of Florida** requests a waiver under the authority of section 1915(b)(1) of the Social Security Act (the Act). The waiver program will be operated directly by the Medicaid agency.

B. Effective Dates: This waiver is requested for a period of 2 years; effective **July 1, 2001** and ending **June 30, 2003**.

C. Waiver Program Name: The Comprehensive HIV/AIDS Managed Care Program.

D. State Contact: The State contact person for this waiver is **David Rogers** and can be reached by telephone at **(850)487-2355** or be e-mailed at **rogersd@fdhc.st.fl.us**.

E. Type of Delivery System: The State will be entering into the following type of contract with an MCO or PHP. The definitions below are taken from federal statute.

Risk-Comprehensive (fully capitated MCOs, HIOs or certain PHPs): Risk-comprehensive contracts are generally referred to as fully-capitated and require that the contractor be an HMO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State Plan service in section 1905(a) of the Act, or three or more mandatory services in that section of the Act. The contractor under this waiver is at-risk for inpatient hospital services and the following other services covered under the State Plan:

- Outpatient Hospital and Emergency Services;
- Physician Services;
- Independent Laboratory and X-Ray Services;
- Prescribed Drug Services*;
- Family Planning Services;
- Home Health Services and Durable Medical Equipment;
- Visual Services;
- Hearing Services;
- Dental Services**; and
- Transportation Services**.

*The contractor will not be at risk for anti-retroviral drugs used in the treatment of HIV/AIDS.

**The contract may have the option of not covering these services under capitated arrangements.

F. Statutory Authority: The State's waiver program is authorized under **Section 1915(b)(1) of the Act**, which provides for a capitated managed care program under which the State restricts the entity from or through which an enrollee can obtain medical care.

G. Other Statutory Authority: The State is also relying upon authority provided in the following sections of the Act.

1915(b)(2) - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among competing health plans in order to provide enrollees with more information about the range of health care options open to them. This authority is cited because the State has an independent enrollment broker. See Section A.III.B Enrollment/Disenrollment.

1915(b)(3) - The State will share cost savings resulting from the use of more cost effective medical care with enrollees by providing them with additional services. These savings must be expended for the benefit of the enrolled Medicaid beneficiaries.

Additional services to be provided under the waiver are:

- Case Management; and
- Home and Community-Based Services (HCBS) covered under the State's Project AIDS Care HCBS waiver program.

The MCO/PHP may provide additional services to enrolled beneficiaries made available through cost savings subject to approval of the State.

1915(b)(4) – The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provisions of covered care and services.

H. Sections Waived: Relying upon the authority of the above Sections of the Act, the State requests a waiver of the following Sections of 1902 of

the Act.

1902(a)(1) - Statewideness--This Section of the Act requires a Medicaid State Plan to be in effect in all political subdivisions of the state. This waiver program is not available throughout the state.

1902(a)(10)(B) - Comparability of Services--This Section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and home and community-based services that will not be available to other Medicaid recipients not enrolled in the waiver program.

1902(a)(23) - Freedom of Choice--This Section of the Act requires Medicaid State Plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the state. Under this program, free choice of providers is restricted. That is, individuals enrolled in this program receive certain services through an MCO or PHP.

I. Geographical Areas of the Waiver Program: The waiver program will not be implemented statewide. The chart below identifies areas of the state where the waiver program will be implemented. (Note: If the State wishes to alter the waiver area at any time during the waiver period, an official waiver modification request will be submitted to HCFA).

Comprehensive HIV/AIDS Managed Care Program Exhibit I Geographic Areas to be Served	
Area	Counties
Medicaid Area 4	Baker, Clay, Duval, Flagler, Nassau, St. Johns and Volusia
Medicaid Area 7	Brevard, Orange, Osceola and Seminole
Medicaid Area 10	Broward
Medicaid Area 11	Dade and Monroe

J. MCO Requirement for Choice: Section 1932(a)(3) of the Act

requires the State to permit individuals to choose from not less than two managed care entities.

This model has a choice of managed care entities. Individuals will choose from at least two MCOs, or an MCO and a PCCM program.

K. Waiver Population Included: The waiver program includes the following target groups of beneficiaries.

- Section 1931 Adults and Related Poverty Level Populations, including pregnant women (TANF/AFDC);
- Blind/Disabled Adults and Related Populations (SSI); and
- Aged and Related Populations.

The waiver program is limited to adults, 21 years of age and older, diagnosed with HIV/AIDS.

L. Excluded Populations: The following beneficiaries will be excluded from participation in the waiver:

- Beneficiaries residing in a nursing facility or an Intermediate Care Facility for the Developmentally Disabled (ICF/DD);
- Beneficiaries enrolled in another managed care program: NOTE: Eligible beneficiaries enrolled in a managed care program other than the plans offered under this waiver may elect to disenroll from such programs (good cause) in order to participate in the comprehensive HIV/AIDS managed care program;
- Beneficiaries who have an eligibility period that is less than 3 months;
- Beneficiaries who have an eligibility period that is only retroactive;
- Beneficiaries who are eligible as medically needy; and
- Beneficiaries who participate in a home and community-based waiver.

M. Automated Data Processing: Federal approval of this waiver request does not obviate the need for the State to comply with the federal automated data processing systems approval requirements described in 42 CFR Part 433, Subpart C, 45 CFR Part 95, Subpart F, and Part 11 of the State Medicaid Manual.

N. Independent Assessment: The State will arrange for an independent assessment of the cost-effectiveness of the waiver and its

impact on beneficiary access to care of adequate quality, at a minimum for the first two waiver periods. This assessment is to be submitted to HCFA at least three months prior to the end of the waiver period.

III. PROGRAM IMPACT

The following informational sections contain required information which describes the waiver program. The information relates to MCOs and, if applicable, PHPs.

A. Marketing: The State permits indirect MCO/PHP marketing to beneficiaries under the supervision and approval of the Medicaid agency. The following are examples of the types of indirect marketing permitted:

- Radio, television and other media advertisements;
- Posters, fliers and other print advertisements;
- Health fairs and public events and subsequent contact with potential enrollees who request further information.
- Marketing in a health care provider's office with approval of the provider. In such cases, (1) the provider may not require a beneficiary to visit any marketer, (2) the marketer may not approach any beneficiary, and (3) information may only be provided to the potential enrollee upon request.

The State permits MCO/PHPs to pay their marketing representatives based on the number of new Medicaid enrollees recruited into the plan. MCO/PHPs must ensure that all marketing representatives are properly licensed pursuant to the requirements of Chapter 641, Florida Statutes. The MCO/PHP must also verify the marketing representative is in good standing with the Florida Department of Insurance.

The State prohibits MCO/PHPs from engaging in certain marketing practices and activities in accordance with Section 409.912(18) and Section 641.3903, Florida Statutes. Prohibited marketing activities include, but are not limited to:

- Offering material or financial gain to any person soliciting, referring or otherwise facilitating beneficiaries enrollment (except for licensed marketing representatives);
- Providing any gift, commission, or any form of compensation to the enrollment broker, its employees or subcontractors;

- Offering promotional items in excess of $1.00 retail value to attract attention (such items must be offered to the general public and not limited to persons who indicate they will enroll in the plan);
- Offering types of insurance such as, but not limited to, accidental death, dismemberment, disability or life insurance.

The State requires MCO/PHP marketing materials to be translated into Spanish and Creole (in Dade County). The State has chosen these languages in the MCO/PHP service area because these languages are spoken by approximately five percent or more of the population. Language translation services are available to all enrollees, regardless of the languages spoken.

MCO Required Marketing Elements. The State will meet all of the following required MCO marketing elements. (Note: These requirements are optional PHP marketing elements). The State will:

- Ensure that all marketing materials are prior approved by the State;
- Ensure that MCO marketing materials do not contain false or misleading information;
- Consult with a Medical Care Advisory Committee (or subcommittee) in review of the MCO marketing materials;
- Ensure that the MCO distributes marketing materials to its entire service area;
- Ensure that the MCO does not offer the sale of any other type of insurance product as an enticement to enrollment;
- Ensure that the MCO does not conduct direct or indirect, door-to-door, telephonic, or other forms of “cold-call” marketing; and
- Ensure that the MCO does not discriminate against individuals eligible to be covered under the contract on the basis of health status or need of health services.

B. Enrollment/Disenrollment: The State will conduct outreach to inform potential enrollees, providers, and other interested parties of the managed care program.

Outreach and educational programs to reach the target population will be conducted through a variety of approaches. Public information campaigns, community meetings and seminars will be used to effectively educate eligible beneficiaries about the waiver program. Additionally, an advisory group will assist in informing the public of the implementation of the waiver program. The advisory group will include representatives from:

- The State Health Office;
- Ryan White Care Act providers; and
- Consumer advocacy groups.

The State contracts with an independent contractor (i.e. enrollment broker) to conduct the enrollment process and related activities. The State undertook a competitive procurement process to contract with an enrollment broker. The contracted enrollment broker, Benova, performs the following functions:

- Dissemination of information materials;
- Operation of a call center; and
- Outreach and education.

Potential enrollees receive information packets by direct mail. The packets are designed to guide beneficiaries through the decision making process. Comparative information on plan choices available and an educational brochure will be sent to beneficiaries.

The enrollment broker operates a call center where choice counselors are available to answer beneficiaries' questions about available plans, PCP availability and other network information.

Educational meetings in local communities are also conducted by the enrollment broker. In these meetings, outreach counselors explain information on available plans, PCP availability, and other network information. These outreach events provide an opportunity for beneficiaries to receive face-to-face assistance in enrolling with an MCO/PHP of their choice.

Enrollment in the waiver program is voluntary for covered populations. The State will make counseling available to potential enrollees regarding their MCO/PHP choices prior to the selection of their plan.

Enrollment counselors will have information and training to assist special populations and persons with special health care needs in selecting appropriate MCO/PHPs and providers based on their medical needs. Enrollees will notify the enrollment broker of their choice of plan by mail, phone or in person at community locations. Typical locations for educational/outreach events include:

- Local Medicaid eligibility offices;

- Health clinics (including FQHCs);
- Hospitals; and
- Other provider offices.

There will be a continuous open enrollment period during which the plans will accept individuals who are eligible to enroll.

The State uses a default enrollment process and a lock-in period of 12 months. However, participation in the Comprehensive HIV/AIDS Managed Care Program is voluntary and enrollees are exempt from the lock-in requirement.

Unless ineligible for managed care enrollment, newly eligible beneficiaries will receive initial notification of the requirement to enroll in a managed care plan. If a beneficiary does not select a plan within the given timeframe, the beneficiary will be auto-assigned to a PCCM (MediPass) provider, a Provider Service Network provider or to an HMO using the established process approved under the MediPass waiver. The beneficiary will not be auto-assigned or default-assigned under this waiver.

The State allows otherwise mandated beneficiaries to request exemption from enrollment in an MCO/PHP. Beneficiaries will be permitted to request exemptions for good cause by contacting the enrollment broker. Each request will be reviewed on a case by case basis. Exemptions from mandatory managed care enrollment are not applicable under this waiver. Beneficiaries must voluntarily elect to enroll in a specialty plan under this waiver.

MCO/PHP enrollees are permitted to disenroll without cause within the first 90 days of the enrollment period with the MCO/PHP. MCO/PHP enrollees will be notified of their ability to disenroll or change MCO/PHPs at the end of their enrollment period at least 60 days before the end of that period. As noted above, MCO/PHP enrollees shall be permitted to disenroll for good cause during the lock-in period. Beneficiaries may disenroll from a specialty plan at any time under this waiver.

The Medicaid agency is responsible for processing disenrollments. The State does permit MCO/PHPs to request disenrollment of enrollees under certain circumstances. Circumstances for involuntary disenrollment requests include:

- Enrollees who are identified by the MCO/PHP as ineligible to participate in the plan;

- Enrollees who do not comply with a recommended health care plan or who miss three consecutive appointments within a continuous six-month period (after oral and written warnings);
- Enrollees whose behavior seriously impairs the MCO/PHP's ability to furnish services to the enrollee or other enrollees (after oral and written warnings);
- Enrollees whom the MCO/PHP is not able to contact (through mail, phone or personal visit) within the first four months of enrollment; and
- Enrollees for whom the MCO/PHP can document no use of plan services within the first four months of enrollment.

The State reviews and approves certain MCO/PHP-initiated requests for enrollee transfers or disenrollments. If reassignment is approved, the MCO/PHP notifies the enrollee in a direct and timely manner of the desire of the MCO/PHP to remove the enrollee from its membership. The enrollee remains a member of the MCO/PHP until another MCO/PHP is chosen or assigned.

C. Entity Type or Specific Waiver Requirements: MCOs/PHPs will be required to comply with all applicable federal statutory and regulatory requirements, including those in Section 1903(m) and 1932 of the Act, and 42 CFR 434 et seq.

The State is requesting a waiver under Section 1915(b)(4) of the Act and believes that the requirements of section 1915(b)(4) are met. Although the organization of the service delivery and payment mechanism for services are different from the current system, the standards for access and quality of care are the same or more rigorous than those in the State's Medicaid State Plan. The MCO/PHP must provide or arrange to provide for the full range of Medicaid services to be provided under the waiver program. There are no restrictions that discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing services.

The State will use a competitive procurement process to select the MCO/PHPs that will operate under the waiver program. Competitive procurement will be conducted in accordance with Chapter 287, Florida Statutes. The State anticipates employing a Request for Proposal (RFP) procedure for competitive procurement. The RFP is a competitive procurement process used for the acquisition of contractual services when it has been determined that the use of an Invitation To Bid (ITB) process is

not appropriate. The RFP method is used when the purchaser has a general knowledge of what is required, but cannot develop the entire set of specifications, which is used in an ITB. The RFP method is also appropriate when the purchaser does not wish to award the contract primarily on the basis of price. In the RFP process, each proposal submitted in response to the RFP is evaluated by a team using a point system.

Per Section 1932(d) of the Act, the State has conflict of interest safeguards with respect to its officers and employees who have responsibilities related to MCO contracts.

D. Services: The Medicaid services MCO/PHPs will be responsible for delivering, prescribing, or referring to are listed in the chart below. The purpose of the chart is to show which of the services in the State Plan are or are not covered in the MCO/PHP contract; which non-covered services, delivered through fee-for-service (FFS), are impacted by the MCO/PHP; and which new services are available only through the MCO/PHP under a waiver of Section 1915(b)(3) of the Act.

Comprehensive HIV/AIDS Managed Care Program Exhibit 2 – Service Covered or Impacted by Plans			
SERVICE	COVERAGE	REIMBURSMENT	FFS IMPACT
Inpatient Hospital	State Plan	Capitation	Yes
Outpatient Hospital	State Plan	Capitation	Yes
Physician	State Plan	Capitation	Yes
Lab and X-Ray	State Plan	Capitation	Yes
Prescribed Drugs	State Plan	Capitation	Yes
Family Planning	State Plan	Capitation	Yes
Home Health/DME	State Plan	Capitation	Yes
Visual	State Plan	Capitation	Yes
Hearing	State Plan	Capitation	Yes
Dental	State Plan	Capitation	Yes
Transportation	State Plan	Capitation	Yes
Case Management	Enhancement	Capitation	N/A
HCBS	Enhancement	Capitation	N/A
Mental Health	State Plan	FFS	No
Nursing Facility	State Plan	FFS	No

The State must ensure that enrollees in MCO/PHPs have access to emergency services without prior authorization, even if the emergency

provider does not have a contractual relationship with the MCO/PHP. For MCOs, "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part. For PHPs, "emergency services" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services, and are needed to evaluate or stabilize an emergency medical condition.

The State ensures enrollee access to emergency services by requiring the MCO/PHP to provide adequate information to all enrollees regarding emergency service access (See also Section G. Enrollee Information and Rights). Additionally, the State ensures enrollee access to emergency services by including contractual requirements for emergency services and care. This includes medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable laws, by other appropriate personnel under the supervision of a physician, to determine whether an emergency medical condition exists, and if it does, the care, treatment, or surgery for a covered service by a physician which is necessary to relieve or eliminate the emergency medical condition, within the service capability of the emergency provider. MCO/PHPs are encouraged to operate 24-hour telephone triage services in order to reduce the costs associated with emergency room visits. However, the State assures that such services may not interfere with an enrollee's ability to access emergency services without prior authorization.

In accordance with 42 CFR 431.519(b), preauthorization by the enrollee's PCP (or other MCO/PHP staff) or requiring the use of participating providers for family planning services is prohibited under the waiver program. Enrollees are informed that family planning services will not be restricted under the waiver program.

In addition to emergency care and family planning, the State requires MCO/PHPs to allow enrollees to self-refer (i.e. access without prior authorization) to the following specialty services. Self-referrals must be within the plan's network:

- Obstetrics/Gynecology (one visit annually with a medically necessary

follow-up visit);
- Chiropractic;
- Podiatry; and
- Dermatology (limited to five visits).

Federally Qualified Health Center (FQHC) services will be made available to beneficiaries under the waiver program. The program is voluntary, and the State expects that an enrollee will have a choice of at least one MCO/PHP which has at least one FQHC as a participating provider. If an enrollee elects not to select an MCO/PHP that provides access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PHP he or she has selected. In the event no MCO/PHP has at least one FQHC as a participating provider, enrollees may obtain FQHC services outside the waiver program through the regular Medicaid Program.

Child Health Check–Up services are not available under the waiver program, given the waiver is restricted to adults age 21 and older.

SECTION B. ACCESS AND CAPACITY

A Section 1915(b) waiver program serves to improve an enrollee's access to quality medical services. A waiver program must assure that services provided are of adequate amount, are provided within reasonable time frames, and are furnished within a reasonable distance from the residence of the enrollees in the program. Furthermore, the proposed waiver program must not substantially impair access to services, and access to emergency and family planning services must not be restricted.

I. ACCESS STANDARDS

A. Availability Standards: The State has established maximum distance and travel time requirements, given beneficiary's normal means of transportation, for enrollee access. The chart below describes standards required of MCO/PHPs.

Comprehensive HIV/AIDS Managed Care Program Exhibit 3 – Typical Travel Time Standard	
PROVIDER	**STANDARD**

PCPs	30 minutes typical travel time
Specialists	60 minutes typical travel time
Ancillary	60 minutes typical travel time
Hospitals	30 minutes typical travel time

The State monitors compliance with these standards through review of the MCO/PHP network prior to contract implementation. MCO/PHPs are required to report any significant network changes, and are subject to an annual review of the MCO/PHP's provider network. Each MCO/PHP will assist enrollees in accessing providers by including pertinent information in member handbooks. This information includes procedures for obtaining services, limitations and general restrictions on provider access. Additionally, each MCO/PHP will provide enrollees with a provider directory which identifies all service sites, pharmacies, hospitals, specialists and ancillary providers. The directory will also include location addresses and telephone numbers for all primary care providers.

B. Appointment Scheduling: The State has established standards for appointment scheduling for enrollee access. Appointment scheduling means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits. The chart below describes standards required of MCO/PHPs.

Comprehensive HIV/AIDS Managed Care Program Exhibit 4 – Appointment Scheduling Standards	
TYPE OF CARE	STANDARD
Urgent Care	Within one (1) day
Routine Care	Within one (1) week
Well Care	Within one (1) month

The State monitors compliance with these standards through a comprehensive annual survey of each MCO/PHP.

II. ACCESS AND AVAILABILITY MONITORING

Enrollee access to care will be monitored as part of each MCO/PHPs Internal Quality Assurance Plan (QAP), annual external quality review (EQR), periodic medical audits, or Independent Assessments (IA). The State will also utilize the following approaches to monitor enrollee access:

- Review of access to emergency or family planning services without

prior authorization;
- Review of denials of referral requests;
- Measurement of enrollee requests for disenrollment due to access issues;
- Tracking of complaints/grievances concerning access issues; and
- Geographic mapping detailing the provider network against beneficiary locations.

Additionally, during monitoring the State will look for the following indications of access problems:

- Long waiting periods to obtain services from a PCP;
- Lack of access to services after a PCP's regular office hours;
- Frequent enrollee requests to change a specific PCP;
- Confusion about how to obtain non-covered services;
- Inappropriate visits to emergency rooms; and
- Non-authorized visits to specialists for medical care.

III.CAPACITY STANDARDS

A. MCO/PHP Capacity Standards: The State has set enrollment limits for MCO/PHPs. Each MCO/PHP is assigned maximum enrollment levels for service areas covered by the plan. The number of Medicaid beneficiaries enrolled in the plan may not exceed the maximum authorized enrollment levels. The MCO/PHP may request an enrollment level increase but may not enroll additional beneficiaries above the approved level without State approval.

The State ensures that the number of providers under the waiver is expected to remain approximately the same compared to the number before the implementation of the waiver. For all provider types in the program, the chart below lists the number of current providers and the number anticipated after the waiver for each geographic area. The number of providers before the waiver represents the number of providers before the waiver serving a comparable population in a given geographic area. In some areas the number of providers for a specific service (e.g. pharmacy) is expected to decrease slightly. In other areas, it is anticipated that MCO/PHP network development will increase the number of providers serving the covered population.

Comprehensive HIV/AIDS Managed care Program Exhibit 5- Expected Impact on Provider Availability								
PROVIDERS	BEFORE THE WAIVER				AFTER THE WAIVER			
	Medicaid Area				Medicaid Area			
	4	7	10	11	4	7	10	11
General Hospital	6	6	17	35	6	6	15	32
Pharmacy	17	19	209	383	17	19	167	306
Physician (MD or DO)	3	24	603	1266	6	24	573	1203
Podiatrist	0	1	13	50	2	2	13	50
Optometrist	0	3	42	56	2	3	42	56
Chiropractor	0	0	18	27	2	2	18	27
Dentist	2	0	33	98	2	2	33	98
Ambulance Svc	1	1	20	9	1	1	20	9
Non-emergency Transportation	2	4	5	8	2	4	5	8
Independent Lab	3	2	13	27	3	2	12	24
Home Health/DME	2	1	57	107	2	2	48	91

B. PCP Capacity Standards: The State has set capacity standards for PCPs within the MCO/PHPs expressed in PCP to enrollee ratio. (Note: In the case of a PHP, a PCP may be defined as a case manager or gatekeeper.) The State monitors compliance with these standards through review of the MCO/PHP network prior to contract implementation. MCO/PHPs are required to report any significant network changes, and are subject to an annual review of the MCO/PHP's provider network.

The State ensures that each plan has sufficient PCPs to ensure adequate accessibility to primary care services. One full-time equivalent (FTE) contract PCP per 1,500 enrollees or one FTE staff PCP per 2,500 enrollees is the current standard. This ratio may be increased by 750 enrollees for each FTE advanced registered nurse practitioner or FTE physician assistant affiliated with the physician.

The State designates the types of providers that can serve as PCPs. A PCP may be a physician practicing as a general or family practitioner, internist, obstetrician, gynecologist, infectious disease specialist, or other specialist approved by the State who furnishes primary care and patient management services. MCO/PHPs are encouraged to engage HIV experts as PCPs (as determined by ongoing patient management of HIV-infected individuals and HIV-specific continuing medical education). If the PCP is not an HIV specialist, the MCO/PHP must have systems in place

to ensure coordination between the PCP and an HIV expert within the plan.

C. Specialist Capacity Standards: The State has set capacity standards for specialty services and monitors access to specialty services. The State monitors compliance with these standards through review of the MCO/PHP network prior to contract implementation. MCO/PHPs are required to report any significant network changes, and are subject to an annual review of the MCO/PHP's provider network.

The State requires particular specialist types to be included in the MCO/PHP network. The MCO/PHP must have specialty coverage sufficient to the number of enrollees served. If sufficient access to specialty care is not available within the plan, the MCO/PHP must provide out-of-network access. The MCO/PHP must assure the availability of the following specialists:

- Anesthesiologist;
- Allergist;
- Cardiologist;
- Chiropractor;
- Dentist;
- Dermatologist;
- Endocrinologist;
- Gastroenterologist;
- General Surgeon;
- Obstetrics/Gynecology (OB/GYN);
- Nephrologist;
- Neurologist;
- Neurosurgeon;
- Occupational Therapist;
- Oncologist;
- Ophthalmologist;
- Optometrist;
- Oral Surgeon;
- Orthopedist;
- Otolaryngologist;
- Pathologist;
- Physical Therapist;
- Podiatrist;
- Psychiatrist;
- Pulmonologist;

- Radiologist;
- Respiratory Therapist;
- Speech Therapist;
- Urologist; and
- Infectious Disease Specialist experienced in HIV/AIDS care.

MCO/PHPs are encouraged to engage providers with experience in treating HIV-infected individuals in all areas of specialty care.

IV. CAPACITY MONITORING

The State will employ the following activities to monitor provider capacity:

- Measurement of provider (PCP)-to-enrollee ratios;
- Annual MCO/PHP reports on provider network;
- Geographic mapping;
- Measurement of enrollee requests for disenrollment due to capacity issues; and
- Tracking of complaints/grievances concerning capacity issues.

V. CONTINUITY AND COORDINATION OF CARE STANDARDS

The State has established the standards to promote continuity and coordination of care. Each enrollee selects or is assigned a primary care provider appropriate to the enrollee's needs. Each provider maintains health records that meet the requirements established by the MCO/PHP, taking into account professional standards. There is appropriate and confidential exchange of information among providers.

Each MCO/PHP will provide case management to its enrollees. Case management services for enrollees include an initial and periodic assessment of an enrollee's medical, prevention, social, and other needs conducted on a face-to-face basis by a case manager in consultation with the enrollee's primary care physician and other providers involved in the care of the enrollee and in consultation with the enrollee or the enrollee's representative. Case management also includes the development and maintenance of a written case management plan for the enrollee based on individualized assessment of the enrollee. The purpose of case management is to assist the enrollee in gaining

timely access to medical, social, and preventive health services regardless of coverage under the waiver program.

Each MCO/PHP will provide adherence services for enrollees which include monitoring enrollee adherence to a prescribed course of treatment, and counseling an enrollee about adherence to a prescribed treatment, as well as activities that assist an enrollee to initiate and sustain practices that promote adherence to a course of treatment.

VI. CONTINUITY AND COORDINATION OF CARE MONITORING

The State will monitor continuity and coordination of care standards through comprehensive annual reviews of each MCO/PHP. The State will explicitly require the MCO/PHPs to coordinate with specific providers (which are not included in the capitated waiver program) to coordinate health care services.

For County Health Departments and Ryan White Care providers, MCO/PHPs must make a good faith effort to execute memoranda of agreement. These memoranda should include services to be provided and protocols for exchange of information as may be necessary to work in a cooperative manner.

SECTION C. QUALITY OF CARE AND SERVICES

A waiver program under Section 1915(b) of the Act may not substantially impair enrollee access to medically necessary services of adequate quality. In addition, 1915(b) waiver programs which utilize MCOs or PHPs must meet certain statutory or regulatory requirements addressing quality of health care. This section describes how the State has planned to meet these requirements.

I. ELEMENTS OF STATE QUALITY STRATEGY

The State includes in its contracts with MCO/PHPs, required internal Quality Assurance and Performance Improvement (QAPI) standards. The State will review and approve each MCO/PHP's written QAP prior to the enrollment of any Medicaid beneficiaries.

The State has an information system that is sufficient to support initial and ongoing operation and review of the QAPI standards. Additionally, the State

requires QAPI standards at least as stringent as those required in federal regulation for access to care, structure and operations, quality measurement and improvement and consumer satisfaction.

The State monitors, on a continuous basis, MCO/PHP adherence to QAPI standards. This is accomplished through on-site monitoring activities conducted at least annually by State agency personnel.

The State will arrange for an annual, independent, external review of the quality outcomes and timeliness of, and access to items and services delivered under each MCO/PHP contract with the State. The State will use an External Quality Review Organization (EQRO) which has not been selected at this time. It is anticipated the EQRO will be a Peer Review Organization (PRO) or a PRO-like entity designated by HCFA. The scope of work for the EQRO will include two types of retrospective medical record audits to verify that each MCO/PHP furnishes accessible, high quality health care to enrolled beneficiaries, while making appropriate utilization management decisions. The EQRO will perform an annual retrospective off-site review for each MCO/PHP. The purpose of this review is to determine whether there is continuity of care for the entire scope of services for which the plan is contractually responsible. The EQRO will also perform quarterly focused reviews of cases where the MCO/PHP has denied authorization for inpatient, specialty, or ancillary services. The purpose of these reviews is to determine that each MCO/PHP is making timely and appropriate utilization management decisions.

II. COVERAGE AND AUTHORIZATION OF SERVICES

The State requires processes and procedures to ensure that contracting MCO/PHPs meet coverage and authorization requirements. Contracts with MCOs/PHPs must identify, define and specify the amount, duration and scope of each service offered, differentiating those services, which may be only available to special needs populations, as appropriate. MCO/PHP contracts must also specify what constitutes “medically necessary services” consistent with the State’s Medicaid State Plan program and provide that the MCO/PHP furnishes services in accordance with this definition.

Comprehensive HIV/AIDS Managed Care program Exhibit 6 – Medical Necessity Definition
“Medically Necessary” or “Medical Necessity”: means services provided in accordance with 42 CFR Section 440.230 and as defined in section 59G-

1.010(166), Florida Administrative Code, to include that medical and allied care, goods, or services furnished or ordered must meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

Medical necessity for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

The fact that a provider has prescribed, recommended, or approved medical or allied goods, or services does not, in itself, make such goods or services medically necessary or a medical necessity or a covered service.

Additionally, contracts with MCO/PHPs must ensure the implementation of written policies and procedures reflecting current standards of medical practice and qualifications of reviewers for processing requests for initial authorization of services or requests for continuation of services. These policies include:

- Specific time frames for responding to requests;
- Requirements regarding necessary information for authorization decisions;
- Provision for consultation with the requesting provider when appropriate;
- Providing for expedited response for urgently needed services;
- Clearly documented criteria for decisions on coverage and medical necessity that are based on reasonable medical evidence or a consensus of relevant medical professionals;
- Mechanisms to ensure consistent application of review criteria and compatible decisions;
- A process for clinical peer reviews of decisions to deny authorization of services on the grounds of medical appropriateness;
- Procedures that ensure prompt written notification of the enrollee and provider when a decision is made to deny, limit, or discontinue authorization of services; and

- Mechanisms that allow providers to advocate on behalf of enrollees within the utilization management process.

III. SELECTION AND RETENTION OF PROVIDERS

The State requires specific policies and procedures to ensure that each MCO/PHP implements a documented selection and retention process for its providers. The State requires MCO/PHPs to have an initial credentialing process for physicians and other licensed health care professionals including members of physician groups that is based on written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid. MCO/PHPs must also have a recredentialing process for physicians and other licensed health care professionals including members of physician groups that is accomplished within time frames set by the State and through a process that updates information obtained through quality assessment and utilization management systems. MCO/PHPs must notify licensing and/or disciplinary bodies or other appropriate authorities when suspension or termination of providers takes place because of quality deficiencies. MCO/PHP may not use formal selection and retention criteria that discriminate against particular practitioners, such as those who serve high risk populations, or specialize in conditions that require costly treatment.

IV. DELEGATION

The State uses certain processes and procedures to ensure that contracting MCO/PHPs oversee and are accountable for any delegated functions in Section C. Quality of Care and Services. Where such functions are delegated by MCO/PHPs, the State Medicaid Agency reviews and approves all model subcontracts and addenda. The State requires agreements to be in writing and to specify any delegated responsibilities. The State monitors to ensure that MCO/PHPs have evaluated the entity's ability to perform the delegated activities prior to delegation.

V. PRACTICE GUIDELINES

MCO/PHPs must have a medical care plan that includes guidelines for use of antiretroviral agents, prophylaxis for opportunistic infections, immunizations and treatment regimens for opportunistic infections and other complications of HIV/AIDS. MCO/PHPs must utilize the most recent standards of the U.S. Public Health Service for laboratory tests, antiretroviral drugs, prophylaxis for opportunistic infections, and immunizations. Explanations must be provided for

exceptions with appropriate references from authoritative sources. MCO/PHPs must include mechanisms in its medical care plan to keep providers current on developments in HIV medicine, including the introduction of new drugs and technologies. Enrollees with AIDS (1993 definition) must be offered antiretroviral agents. Protease inhibitors should be offered in combination with other antiretroviral agents to a majority of enrollees. All enrollees receiving antiretroviral agents should receive combination therapy according to DHHS guidelines (latest version unless they are receiving agents or a treatment IND) or participate in an approved clinical trial.

VI. HEALTH INFORMATION SYSTEMS

The State requires specific processes and procedures to ensure that contracting MCO/PHPs maintain a health information system that collects, analyzes, integrates and reports data and can achieve the objectives of the Medicaid Program. The State requires that MCO/PHPs provide information on utilization, grievances, and disenrollments.

The State requires that the MCO/PHP collect data on services furnished to enrollees through an encounter data system or such other methods approved by the State. The MCO/PHP must be capable of recording sufficient patient data to identify the provider who delivered services to Medicaid enrollees, and verifying whether services reimbursed by Medicaid were actually furnished to enrollees by providers and subcontractors. Additionally, MCO/PHP health information systems must be sufficient to allow the State agency to monitor the performance of the MCO/PHP using systematic, ongoing collection and analysis of valid and reliable data. MCO/PHPs must ensure that information and data received from providers are accurate, timely and complete.

MCO/PHPs must provide periodic numeric data reports describing clinical and related information for the Medicaid enrolled population. This information includes reports related to health services utilization. MCO/PHPs report encounter data through quarterly Inpatient Discharge Reports which detail hospital inpatient utilization information and a quarterly Pharmacy Encounter Record detailing each prescription paid for by the MCO/PHP. Additionally, MCO/PHPs will submit summary service utilization reports within 45 days after the end of the quarter being reported. For reporting purposes, quarters end, September, December, March and June. Service Utilization Summary Reports include:

- Enrollee inpatient days provided in the quarter;

- Enrollee visits to emergency centers;
- Enrollee visits to physicians' offices;
- Enrollee visits to non-physicians' offices;
- Enrollee visits to outpatient centers;
- Number of enrollee prescriptions;
- Number of dental services provided; and
- Number of transportation trips provided.

The State requires that MCO/PHPs maintain health information systems sufficient to support initial and ongoing operations, and to collect, integrate, analyze and report data necessary to implement its QAP. The MCO/PHP must ensure that each provider furnishing services to enrollees maintains an enrollee health record in accordance with standards established by the organization that take into account professional standards.

MCO/PHPs must provide periodic numeric data reports describing clinical and related information for the Medicaid enrolled population. This information includes reports related to outcomes of health care. The State establishes Quality Indicators which are calculated for each calendar year from January 1 through December 31. This information is reported by MCO/PHPs by June 30 of each year. MCO/PHPs must provide for certification by an independent auditor that the quality indicator data reported has been fairly and accurately presented. Measures used will constitute a subset of HEDIS and will be selected by the State annually based on the current recommendation of the National Committee for Quality Assurance (NCQA) for Medicaid HMO reporting.

VII. QUALITY ASSESSEMENT AND PERFORMANCE IMPROVEMENT

The State requires specific processes and procedures to ensure that contracting MCO/PHPs maintain an adequate Quality Assurance Program (QAP). MCO/PHPs must have an adequate organizational structure which allows for clear and appropriate administration and evaluation of the QAP. The MCO/PHP must have a quality assurance review authority to direct and review all activities related to the QAP. Each MCO/PHP QAP must be approved by the Medicaid agency and contain, at a minimum, the following components:

- Quality-of-care studies;
- Linkage to other management activities;
- Peer review;
- Utilization management; and

- Independent survey of member satisfaction.

The State requires MCO/PHPs to conduct quality-of-care studies which target specific conditions and specific health services delivery issues for focused individual practitioner and system-wide monitoring and evaluation. MCO/PHPs must use current or Medicaid approved clinical care standards or practice guidelines to objectively evaluate the care the entity delivers or fails to deliver for the targeted clinical conditions. MCO/PHPs must also use quality indicators derived from clinical care standards or practice guidelines to screen and monitor care and services delivered. MCO/PHPs are allowed to collaborate with one another on quality improvement projects, subject to the approval of the State Medicaid agency, or to conduct multi-year projects developed in consultation with the State Medicaid agency.

SECTION D. FRAUD AND ABUSE

The State will promote the prevention, detection, and reporting of fraud and abuse in managed care by ensuring both the State and the MCO/PHPs have certain provisions in place for the waiver program.

I. STATE MECHANISMS

The State has systems to avoid duplicate payments (e.g. denial of claims for services which are the responsibility of the MCO/PHP, by the State's claims processing system). The State has developed mechanisms for preventing, detecting, pursuing, and reporting fraud and abuse in the managed care programs, which will be applicable to specialty plans under this waiver.

II. MCO/PHP FRAUD PROVISIONS

The State requires MCO/PHPs to have an internal plan for preventing, detecting, and pursuing fraud and abuse. The State also requires MCO/PHPs to report suspected fraud and cooperate with State (including Medicaid Fraud Control Unit) investigations.

SECTION E. SPECIAL POPULATIONS

I. GENERAL PROVISIONS FOR SPECIAL POPULATIONS

This waiver program is designed to cover a special population, adults with HIV/AIDS. The State has developed and implemented processes to collaborate and coordinate with, on an ongoing basis, agencies which serve this special population, advocates for the special needs population, and special needs beneficiaries.

II. STATE REQUIREMENTS FOR MCO/PHPs

Key elements to address the needs of this special population are incorporated into the design of this waiver program. As part of its criteria for contracting with an MCO/PHP, the State will assess the MCO/PHP's skill and experience level in accommodating people with special needs. The State has required the MCO/PHP to provide case management services for individuals enrolled in the waiver program. See Section B.V. The State requires MCO/PHPs to either contract or create arrangements with providers who have traditionally served the special needs population. See Section B.VI. The State will include MCO/PHP contract provisions which allow beneficiaries who use specialists frequently for their health care to be allowed to maintain these specialists as PCPs. See Section B.III.B. The State will require MCO/PHPs to utilize clinical guidelines appropriate for the special needs population. See Section C.V.

SECTION F. COMPLAINTS, GRIEVANCES, AND FAIR HEARINGS

MCO/PHPs are required to have an internal grievance procedure, approved in writing by the State, providing for prompt resolution of issues and assuring participation of individuals with authority to order corrective action. The procedure allows an enrollee or a provider on behalf of an enrollee to challenge the denial of, or payment for services as required by section 1932(b)(4) of the Act.

The State provides Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 subpart E, including

- Informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action;
- Ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if the State takes action without advance notice and as required in accordance with the State's fair hearing

policies;
- Informing enrollees of the procedures to request a fair hearing and procedures by which benefits can be continued or reinstated; and
- Other requirements for fair hearings found in federal regulations.

I. DEFINITIONS

The State uses the following definitions under the waiver program.

Complaint – In accordance with section 641.47(5), Florida Statutes, a complaint is any expression of dissatisfaction by a member, including dissatisfaction with the administration, claims practices, or provision of services, which relates to the quality of care provided by a provider pursuant to the plan's contract and which is submitted to the plan or to a state agency. A complaint is part of the informal steps of a grievance procedure and is not part of the formal steps of a grievance procedure unless it is defined as a grievance.

Grievance – In accordance with Section 641.47(10), Florida Statutes, a grievance is a written complaint submitted by or on behalf of a member or a provider to the plan or the agency regarding the: availability, coverage for the delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; claims payment, handling, or reimbursement for health care services; or matters pertaining to the contractual relationship between a member or provider and the plan or agency.

Grievance Procedure – A written protocol and procedure detailing an organized process by which managed care members or providers may express dissatisfaction with care, goods, services or benefits received and the resolution of these dissatisfactions.

II. STATE REQUIREMENTS AND MONITORING ACTIVITIES

A. Required Elements: The State employs various requirements and monitoring activities in effect for MCO/PHP grievance processes. Enrollees are informed about their complaint, grievance and fair hearing rights at the time of MCO/PHP enrollment and on a periodic basis thereafter.

The State requires MCO/PHPs to have a written internal grievance procedure, providing for prompt resolution of issues and assuring participation of individuals in authority. The MCO/PHP grievance process is approved by the State prior to its implementation.

Enrollees are informed about their fair hearing rights at the time of Medicaid eligibility determination and at the time of any action as defined in 42 CFR 431, Subpart E. An MCO/PHP enrollee can request a fair hearing under the State's fair hearing process. The State ensures that enrollees may request continuation of benefits or reinstatement of services during the course of treatment during a fair hearing appeal. The State informs enrollees of the procedures by which benefits can be continued or reinstated.

B. Optional Elements: The internal grievance procedure used by the MCO/PHPs includes optional procedures required by the State's more stringent grievance provisions. Each MCO/PHP will develop and implement specific grievance procedures approved by the State, including an expedited grievance review process when an enrollee's health is at risk.

MCO/PHP grievance procedures must specify a time frame from the date of action for the enrollee to request a grievance resolution or fair hearing, and include time frames for resolution for MCO/PHP grievances. MCO/PHPs must provide the enrollee with assistance completing forms or other assistance necessary in filing complaints or grievances. The MCO/PHP acknowledges receipt of each complaint and grievance when received and explains to the enrollee the process to be followed in resolving his or her issue. Enrollees are permitted to appear before MCO/PHP personnel responsible for resolving grievances. If the focus of the grievance is a denial based on lack of medical necessity, one of the reviewers is a physician with appropriate expertise. MCO/PHPs must notify the enrollee in writing of the grievance decision and further opportunities for appeal, as well as procedures available to challenge or appeal the decision. MCO/PHP grievance procedures must also set time frames for the MCO/PHP to authorize or provide a service if the decision is overturned or reversed through the grievance or fair hearing process.

MCO/PHPs must maintain a log of all complaints and grievances and their resolution. MCO/PHPs are required to send the State a summary of individual complaints and grievances on at least a quarterly basis.

SECTION G. ENROLLEE INFORMATION AND RIGHTS

This Section describes the process for informing enrollees and potential enrollees about

the waiver program and protecting their rights once enrolled. The information in this section (e.g. enrollee handbooks, enrollment information) is considered to be marketing material because it is sent directly to enrollees. However, the traditional marketing materials (e.g. television and radio advertising) are addressed in Section A.

I. ENROLLEE INFORMATION – COMPREHENSION

The State will ensure that enrollee materials provided by the State, the enrollment broker, and the MCO/PHP are clear and easily understandable. Enrollment materials are to be translated into Spanish and Creole in Dade County. The State has chosen these languages in the MCO/PHP service area because these languages are spoken by approximately five percent or more of the population. Translation services are available to all enrollees, regardless of the languages spoken. Additionally, every new enrollee will have access to a toll-free number to call for questions or additional information.

II. ENROLLEE INFORMATION – CONTENT

A. State and/or Enrollment Broker Information: The State and/or its enrollment broker provide the following information to enrollees or potential enrollees:

- An initial notification letter;
- A form for enrollment;
- A list of plans serving the enrollee's geographic area;
- Comparative information about plans;
- Information on how to obtain choice counseling;
- Information on how to obtain services not covered by the MCO/PHP but covered under the State plan;
- Information on enrollees' right to disenroll without cause in the first 90 days of the enrollment period; and
- Notification 60 days prior to the end of the enrollment period of the right to change MCO/PHPs.

B. MCO/PHP Information: The State requires the MCO/PHP to provide, written information on the following items to enrollees and potential enrollees. Unless otherwise noted, required items must be provided upon actual enrollment into the MCO/PHP.

- Enrollee rights;
- Enrollee responsibilities;
- Procedures for obtaining services including authorization requirements;

- After-hours and emergency coverage;
- Procedures for obtaining non-covered or out-of-area services;
- Any special conditions or charges that may apply to obtaining services;
- Charges to enrollees, if applicable;
- Policies on referrals for specialty care and other services not furnished by the enrollee's primary care provider;
- Procedures for changing primary care providers;
- Procedures for obtaining mental health and substance abuse services;
- The right to obtain family planning services from any Medicaid-participating provider;
- Information explaining the complaints and grievance procedures for resolving enrollee issues at enrollment and upon request;
- Disclosure to enrollees of their right to adequate and timely information related to physician incentives;
- Information on physician incentive programs upon request; and
- Qualifications and availability of network providers, including information about any restrictions on enrollees' ability to select among network providers upon request.

III. ENROLLEE RIGHTS

The State requires MCO/PHPs to have written policies with respect to enrollee rights and to communicate these policies to enrollees, staff and providers. Each Medicaid enrollee shall be covered by the Florida Patient's Bill of Rights and Responsibilities contained in Section 381.026, Florida Statutes. The State also requires that MCO/PHPs ensure compliance with federal and state laws affecting the rights of enrollees such as civil rights and anti-discrimination laws, including the Americans with Disabilities Act. MCO/PHPs must implement procedures to ensure that enrollees are not discriminated against in the delivery of medically necessary services.

The State requires MCO/PHPs to have written policies and procedures that allow enrollees to have access to his or her medical records in accordance with applicable federal and state law. MCO/PHPs must implement procedures to ensure the confidentiality of health and medical records and of other information about enrollees.

The State requires that MCO/PHPs ensure that each enrollee has the right to refuse care from specific providers and that MCO/PHPs comply with requirements of federal and state law with respect to advance directives.

IV. MONITORING COMPLIANCE

The State uses various methods to monitor compliance with the requirements for enrollee information and enrollee rights. The State will approve enrollee information prior to its release by the MCO/PHP. The State will also monitor MCO/PHP compliance with enrollee materials and enrollees' rights through comprehensive annual review of each MCO/PHP.

SECTION H. COST EFFECTIVENESS

In order to demonstrate cost effectiveness, a waiver request must show that the cost of the waiver program will not exceed what Medicaid costs would have been in the absence of the waiver. With respect to waivers involving capitated reimbursement, a State's computation of its Upper Payment Limit (UPL), as required by 42 CFR 447.361, may serve the dual purpose of computing the projected Medicaid costs in the absence of the waiver. The UPL is only one component of waiver cost effectiveness, which must also include comparisons of a State's administrative costs and relevant FFS costs with and without the waiver as well.

I. DESCRIPTION OF THE COST-EFFECTIVENESS CALCULATION PROCESS

In general, the UPL for capitation contracts on a risk basis (e.g., MCO, HIO, or PHP) is the State agency's estimated cost of providing the scope of services covered by the capitation payment if these services were provided on a fee-for-service (FFS) basis. Documentation for the costs without the waiver are calculated on a per member per month basis. In order to determine cost-effectiveness, the State first estimates the number of member months for the target population which will participate in the waiver program. The base year and the source of the without-waiver data must be identified. The member months estimations are based on the actual State eligibility data in the base year.

The purpose of the exhibit below is to provide data on projected enrollment during the waiver period. Projected enrollment data are needed to determine whether the waiver is likely to be cost effective. The data are also useful in assessing future enrollment changes in the waiver. The base year period used to estimate enrollment under the waiver is State Fiscal Year 1998-99. Base year data are from a comparable population to the individuals to be included in the waiver.

Comprehensive HIV/AIDS Managed Care Program Exhibit 7 – Estimated Member Months			
Area/Status	**Base Year**	**Waiver Year 1**	**Waiver Year 2**
Area 4	15,536	6,991	9,322
HIV	1,693	762	1,016
AIDS	13,843	6,229	8,306
Area 7	18,594	8,367	11,156
HIV	2,027	912	1,216
AIDS	16,567	7,455	9,940
Area 10	19,618	8,828	11,771
HIV	2,138	962	1,283
AIDS	17,480	7,866	10,488
Area 11	40,260	18,117	24,156
HIV	4,388	1,975	2,633
AIDS	35,872	16,142	21,523
Total Member Months	94,008	42,303	56,405
% Increase			33%

Without-waiver-costs are created using a FFS UPL based on FFS data with FFS utilization and FFS inflation assumptions. The State used FFS Medicaid historical data to develop utilization and inflation trend rates.

Once the base year costs were established, the State made adjustments to that data in order to update to the year to be covered by the capitation contract. These adjustments represent the impact on Medicaid costs from such things as inflation, utilization factors, administrative expenses, program changes, reinsurance or stop-loss limits, and third party liability. When these adjustments are computed and factored into the base year costs, the end result is a projected UPL for the year under contract (i.e. without-waiver costs).

The State then calculated the aggregate costs without the waiver and the aggregate costs anticipated with the waiver. To obtain approval for the authority to waive federal Medicaid regulations, the State must clearly demonstrate that, when compared, payments to the contractor do not exceed the UPL, and costs under the waiver do not exceed costs without the waiver.

Cost effectiveness for 1915(b) waivers is measured in total computable dollars (federal and state share). The State should have Per Member Per Month (PMPM) costs for the 2-year period equal to or less than projected costs in the absence of an approved waiver. The State will not be held accountable for caseload changes when submitting its waiver renewal cost-effectiveness calculations for services. In addition, the State will also not be held accountable for benefit package, payment rate, or other programmatic

changes made to the waiver program. Waiver expenditures are reported on the Quarterly Medicaid Statement of Expenditures (Form HCFA-64 Report), according to reporting instructions in the State Medicaid Manual, Section 2500.

II. WITHOUT-WAIVER DATA SOURCES AND ADJUSTMENTS

Actual cost and eligibility data are used for base year PMPM computations. The base year period used to estimate costs without the waiver is State Fiscal Year 1998-99. The purpose of the exhibit below is to explain the data sources and reimbursement methodology for base year costs. Additionally, the exhibit is intended to identify adjustments that must be made to base-year costs in order to arrive at the UPL for capitated services and the without-waiver costs for all waiver services.

Required adjustments a. through g. (below) must be completed by the State. Optional adjustments h. through s. (below) should be completed if the adjustment applies. For each optional adjustment that is not applied, the State has made a policy decision to not include that adjustment. If the State has made an adjustment to its without-waiver cost, information on the basis and methodology information below must be completed and mathematically accounted for in the cost-effectiveness demonstration. Most adjustments are computed on a statewide basis, although some may be specific to certain geographic areas. Similarly, some adjustments apply to all service categories while others only apply to specific services provided.

Comprehensive HIV/AIDS Managed Care Program Exhibit 8 – Without-Waiver Data Sources & Adjustments Using SFY 1998-99 Data from FMMIS as Base Year				
Service Category		**Coverage**	**Reimbursement**	
Inpatient Hospital		State Plan	Capitated	**Adjustment Made**
Outpatient Hospital		State Plan	Capitated	
Physician		State Plan	Capitated	
Other Professional		State Plan	Capitated	
Clinical Services		State Plan	Capitated	
Lab and X-Ray		State Plan	Capitated	
Prescribed Drugs		State Plan	Capitated	
Family Planning		State Plan	Capitated	
Home Health/DME		State Plan	Capitated	
Vision		State Plan	Capitated	
Hearing		State Plan	Capitated	
Dental		State Plan	Capitated	
Transportation		State Plan	Capitated	
Case Management		Enhancement	Capitated	
HCBS		Enhancement	Capitated	
Adjustments to Base Year				
a.	DSH Payments			No
b.	IBNR			Yes
c.	Inflation			Yes
d.	TPL			Yes
e.	FQHC & RHC Cost Settlement Adj.			Yes
f.	Payments/Recoupments not through MMIS			No
g.	Pharmacy Rebate Factor			Yes
h.	Admin. Cost Calculations			Yes
i.	Copayment Adjustment			No
j.	Data Smoothing			No
k.	Investment Income Factor			No
l.	PCCM Fee Deduction			No
m.	Pooling Catastrophic Claims			No
n.	Pricing			No
o.	Programmatic/Policy Changes			Yes
p.	Regional Factors to Small Pops.			Yes
q.	Retrospective Eligibility			No
r.	Utilization			Yes
s.	Other Adjustments			No
Adjustments affecting With-Waiver Costs				
a.	Reinsurance or Stop/Loss			No
b.	Incentive/Bonus Payments			Yes
c.	Other Adjustments			Yes

A description of each adjustment factor is provided below. The HCFA Regional Office may require more documentation during the UPL and contract rate approval process regarding methodologies used to develop each adjustment. The size and effect of each adjustment is noted in the development of without-waiver costs.

A. **Disproportionate Share Hospital (DSH) Payments:** Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCO/PHPs. Note: Section 4721(c) does permit an exemption to the direct DSH payment. Therefore, DSH payments are not included in cost-effectiveness calculations. The State assures HCFA that DSH payments are excluded from base year data and from adjustments.

B. **Incurred But Not Reported (IBNR):** Due to the lag between dates of service and dates of payment, completion factors must be applied to data to ensure that the base data represents all claims incurred during the base year. The IBNR factor increases the reported totals to an estimate of their ultimate value after all claims have been reported. Claims in base year data source are based on date of service.

C. **Inflation:** This adjustment reflects the expected inflation in the FFS program between the base year and Year One and Year Two of the waiver period. Inflation adjustments are made specific to the service category and are expressed as percentage factors. The State used historical FFS experience to develop inflation rates.

D. **Third Party Liability (TPL):** This adjustment is used only if the State will not collect and keep TPL payments for post-pay recoveries. Because the MCO/PHP will collect and keep TPL, then the base year cost is reduced by the amount to be collected. Post-pay recoveries were estimated and the Base Year costs were reduced by the amount of TPL to be collected by MCO/PHPs.

E. **FQHC and RHC Cost-Settlement Adjustment:** This adjustment accounts for the requirement of States to make supplemental payments for the difference between the rates paid by an MCO/PHP to an FQHC or RHC and the reasonable costs of the FQHC or RHC. The UPL and estimated MCO/PHP rates include payments for comparable non-FQHC or non-RHC primary care service expenditures. Cost-settlement supplemental payments made to FQHCs/RHCs are included in without-waiver costs, but not included in the base year UPL costs, adjustments, or estimated MCO/PHP rates. The State has not accounted for any potential

phase-down in FQHC/RHC payments beginning in Fiscal Year 2000, as outlined by Section 4712 of the BBA.

F. **Payments / Recoupments not Processed through the Medicaid Management Information System (MMIS):** This adjustment addresses any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system. The State had no recoupments/payments outside of the MMIS and none are included in the UPL.

G. **Pharmacy Rebate Factor**: Rebates the State received from drug manufacturers are deducted from UPL base year costs because pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated UPL may result. The State determined the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. The population occur in the same proportion as the rebates for the total Medicaid population.

H. **Administrative Cost Calculation:** The administrative expense factor should include administrative costs that would have been attributed to members participating in the MCO/PHP if these members had been enrolled in FFS. Only those costs for which the State is no longer responsible should be recognized. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) volume costs.

I. **Copayment Adjustment:** This adjustment accounts for any copayments that are collected under the FFS program but not to be collected in the capitated program. States must ensure that these copayments are included in the UPL if not to be collected in the capitated program. Claims data used for UPL development already included copayments and no adjustment was necessary.

J. **Data Smoothing Calculations and Predictability:** Costs in rate cells are smoothed through a cost-neutral process to reduce distortions across cells and adjust rates toward the statewide average rate. These distortions are primarily the result of small populations, disproportionate access in certain areas of the State, or extremely high cost catastrophic claims. The State has chosen not to make this adjustment.

K. **Investment Income Factor:** This factor adjusts capitation rates and UPLs because FFS claims are paid after a service is provided while payments under managed care are made before the time of services. The State has chosen not to make this adjustment.

L. **Primary Care Case Management (PCCM) Fee Deduction:** When a State transitions from a PCCM program to a capitated program and uses the PCCM claims data to create capitated UPLs, any management fees paid to the PCCM must be deducted from the UPL. PCCM claims data were used to create capitated UPLs and management fees but were not deducted.

M. **Pooling for Catastrophic Claims:** This adjustment should be used if it is determined that a small number of catastrophic claims are distorting per capita costs in some rate cells and are not predictive of future utilization. The State has chosen not to make this adjustment.

N. **Pricing:** The adjustments account for changes in the cost of services under FFS. For example, changes in fee schedules, changes brought about by legal action, or changes brought about by legislation. The State has chosen not to make this adjustment.

O. **Programmatic/Policy Changes:** These adjustments are made to account for any FFS programmatic changes that are not cost neutral and affect the UPL. For example, federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. The State has made this adjustment to account for proposed pharmacy controls to be implemented in Dade county.

P. **Regional Factors Applied to Small Populations:** This adjustment is to be applied when there are a small number of eligible months in certain rate cells and large variations in PMPMs across these categories and regions exist. The State has made this adjustment.

Q. **Retrospective Eligibility:** States that have allowed retrospective eligibility under FFS must ensure that the costs of providing retrospective eligibility are not included in the UPL. The rationale for this is that MCO/PHPs will not incur costs associated with retrospective eligibility because capitated eligibility is prospective. The State has chosen not to make adjustment because it was not necessary given the State's enrollment criteria.

R. **Utilization:** This adjustment reflects the changes in utilization of FFS services between the Base Year and the beginning of the waiver and between Year One and Year Two of the waiver. The State estimated the changes in technology and/or practice patterns that would occur in FFS delivery, regardless of capitation. Utilization adjustments were made to reflect the expected increase in the number of prescriptions for HAART drugs and expressed as percentage factors.

S. **Other Adjustments:** These adjustments include, but are not limited to guaranteed eligibility and risk-adjustment. No other adjustments have been made to the Base Year costs.

III. WITHOUT-WAIVER COST DEVELOPMENT

The purpose of the following exhibit is to calculate without-waiver costs on a PMPM basis. NOTE: HCFA will measure the cost effectiveness of the waiver in the renewal based on this PMPM calculation and the actual enrollment under the waiver. These amounts represent the final PMPM amounts which will be applied to actual enrollment in measuring cost effectiveness. The State will not be held accountable for caseload changes when submitting its waiver renewal cost-effectiveness calculations.

The State should have PMPM costs for the 2-year period equal to or less than projected without-waiver costs as calculated below.

Comprehensive HIV/AIDS Managed Care Program Exhibit 9 – Without-Waiver Costs – Year 1								
	Area 4		Area 7		Area 10		Area 11	
PMPM Component	HIV	AIDS	HIV	AIDS	HIV	AIDS	HIV	AIDS
Base Year Member Months	1,693	13,843	2,027	16,567	2,138	17,480	4,388	35,872
Base Year Aggregate Costs	$21,804,925		$24,272,859.89		$34,899,494.72		$112,595,873.99	
Base Year PMPM								
Inpatient Hospital	69.54	257.86	64.75	240.08	88.17	326.95	138.55	513.76
Outpatient Hospital	42.12	99.22	36.55	86.11	43.72	102.99	65.83	155.09
Physician	60.66	142.91	58.12	136.93	92.83	218.69	145.33	342.38
Other Professional	.28	.67	.14	.33	.42	.98	.12	.28
Clinic Services	7.05	16.62	6.71	15.80	2.35	5.55	5.79	13.64
Lab & X-ray	2.47	5.82	2.71	6.37	7.08	16.69	11.67	27.49
Prescribed Drugs	315.60	746.42	293.85	694.98	400.16	946.42	628.80	1487.19
Family Planning	.57	1.34	.50	1.18	.42	.98	.48	1.12
Home Health/DME	14.86	35.00	17.00	40.05	27.21	64.11	45.75	107.78

Vision	1.24	2.93	1.13	2.66	1.56	3.67	2.75	6.47
Hearing	.21	.49	.17	.39	.25	.58	.42	.98
Dental	1.98	4.66	1.80	4.24	2.39	5.64	3.82	9.00
Transportation	18.36	43.26	14.61	34.43	11.72	27.60	16.35	38.53
Subtotal of Capitated Services	534.94	1357.20	498.04	1263.55	678.28	1720.85	1065.66	2703.71
IBNR adjustment	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%
--size & effect	7.49	19.00	6.97	17.69	9.50	24.09	14.92	37.85
Inflation adjustment	6.07%	6.07%	5.89%	5.89%	6.2%	6.2%	6.8%	6.8%
--size & effect	32.47	82.38	29.33	74.42	42.05	106.69	72.46	183.85
TPL adjustment	(1%)	(1%)	(1%)	(1%)	(1%)	(1%)	(1%)	(1%)
--size & effect	-5.35	-13.57	-4.98	-12.64	-6.78	-17.21	-10.66	-27.04
FQHC & RHC adjustment	(.08%)	(.08%)	(.49%)	(.49%)	(.02%)	(.02%)	(.31%)	(.31%)
--size & effect	-0.43	-1.09	-2.44	-6.19	-0.14	-0.34	-3.30	-8.38
Rx Rebate adjustment	(5.5%)	(5.5%)	(5.4%)	(5.4%)	(5.2%)	(5.2%)	(6.1%)	(6.1%)
--size & effect	-29.42	-74.65	-26.89	-68.23	-35.27	-89.48	-65.00	-164.93
Admin. Adjustment	1.54%	1.54%	1.54%	1.54%	1.54%	1.54%	1.54%	1.54%
--size & effect	8.24	20.90	7.67	19.46	10.45	26.50	16.41	41.64
Program/Policy Changes	0	0	0	0	0	0	(28.74%)	(28.74%)
--size & effect	0	0	0	0	0	0	-306.33	-777.12
Geo/Small Pop adjust	.482608	0	.432951	0	.301398	-.01453	0	-.00901
--size & effect	258.17	0.00	215.63	0.00	204.43	-25.00	0.00	-24.37
Rx Utilization adjust	7.26%	7.26%	7.26%	7.26%	7.26%	7.26%	7.26%	7.26%
--size & effect	3.88	9.85	3.62	4.92	4.92	12.49	7.74	19.63
Capitated Year 1 PMPM Cost (base year after adjustments)	809.99	1400.02	726.95	1297.23	907.44	1758.59	791.90	1984.84
Behavioral Health	12.25	31.08	11.29	28.63	15.48	39.27	24.44	62.00
Inflation adjustment	10.57%	10.57%	10.57%	10.57%	10.57%	10.57%	10.57%	10.57%
--size & effect	1.29	3.29	1.19	3.03	1.64	4.15	2.58	6.55
Other Services	45.14	114.52	41.58	105.50	57.03	144.69	90.04	228.45
FFS Year 1 PMPM (base year after adjustment)	58.68	148.89	54.06	137.16	74.15	188.11	117.06	297.00
Waiver Year 1 PMPM	868.67	1548.91	781.01	1434.39	981.59	1946.70	908.96	2281.84

Comprehensive HIV/AIDS Managed Care Program Exhibit 10 – Without-Waiver Costs – Year 2								
	Area 4		Area 7		Area 10		Area 11	
PMPM Component	HIV	AIDS	HIV	AIDS	HIV	AIDS	HIV	AIDS
Capitated Year 1 PMPM Cost	809.99	1400.02	726.95	1297.23	907.44	1758.59	791.90	1984.84
Inflation adjustment	6.07%	6.07%	5.89%	5.89%	6.2%	6.2%	6.8%	6.8%
--size & effect	49.16	84.98	42.82	76.41	56.26	68.09	53.85	134.97
FQHC & RHC adjustment	(.08%)	(.08%)	(.49%)	(.49%)	(.02%)	(.02%)	(.31%)	(.31%)
Rx Rebate adjustment	(19%)	(19%)	(19%)	(19%)	(19%)	(19%)	(19%)	(19%)
Admin. Adjustment	1.54%	1.54%	1.54%	1.54%	1.54%	1.54%	1.54%	1.54%
Geo/Small Pop. Adjust	.482608	0	.432951	0	.301398	-.01453	0	-.00901
Capitated Year 2 PMPM Cost (base year after adjustments)	859.15	1485.00	769.77	1373.64	963.70	1826.68	845.75	2119.81
FFS Year 1 PMPM Cost	58.68	148.89	54.06	137.16	74.15	188.11	117.06	297.00
Behavioral Health	13.54	34.37	12.48	31.66	17.12	43.42	27.02	68.55
Inflation adjustment	10.57%	10.57%	10.57%	10.57%	10.57%	10.57%	10.57%	10.57%
--size & effect	1.43	3.63	1.32	3.35	1.81	4.59	2.86	7.25
Other Services	45.14	114.52	41.58	105.50	57.03	144.69	90.04	228.45
FFS Year 2 PMPM (base year after adjustment)	60.11	152.52	55.38	140.51	75.96	192.70	119.92	304.25
Waiver Year 2 PMPM	919.26	1637.52	825.15	1513.67	1039.66	2019.38	965.67	2424.06

IV. WITH-WAIVER COST DEVELOPMENT

An actuarial basis for the capitation rates for both MCOs and PHPs must be developed to demonstrate that payments to the contractor will be on an actuarially sound basis, in accordance with the regulations at 42 CFA 434.61. Specifying the "actuarial basis" of the capitation rate means providing a description of the methodology the State uses to determine its capitation rate(s). Among the possible methods a State might use are: a percentage of the UPL; a budget-based rate (e.g., the MCO/PHP's cost); and the contractors community rate with adjustments as appropriate (e.g., for the scope of services in the State's contract and the utilization characteristics of the Medicaid enrollees).

The State assures HCFA that the capitated rates will be equal to or less than the UPL. The capitation rates will be set in an actuarially sound manner. The State has retained the services of William M. Mercer, Inc. (Mercer) to assist in setting HIV/AIDS capitation rates. Mercer is one of the world's leading employee benefits and human resource consulting firms. Mercer has assisted with the development of rate setting methodologies and capitation rates for an HIV/AIDS population in several states. As specified in 42 CFR 447.361, payments to contractors must be no more than the cost of providing those same services on a FFS basis, to an actuarially equivalent nonenrolled population group (i.e., no greater than the UPL). The State will submit all capitated rates to the HCFA Regional Office for prior approval.

With-waiver costs are the sum of estimated payments to capitated providers, FFS payments for managed care enrollees that are controlled or affected by managed care providers, and the costs to the State of implementing and maintaining the managed care program. In order to demonstrate that the rates do not exceed the UPL, cost without the waiver are set at 92% of UPL. The State is requesting a 1915(b)(3) waiver and will be providing non-state plan medical services. The State anticipates requiring plans to spend a portion of the capitated rate on additional non-State plan medical services. The estimated amount, expressed as a percentage of the PMPM, that will be spent on average on non-State plan covered medical services is 2.5%. This amount is built into the State's with-waiver costs as a portion of the capitated rates.

V. WITH-WAIVER COST ADJUSTMENTS (in addition to the Capitated or FFS Base Year Cost Adjustments)

A. Reinsurance or Stop/Loss Coverage: Reinsurance may be provided by States to MCO/PHPs when MCO/PHPs exceed certain payment thresholds for individual enrollees. Stop/loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PHP will be responsible. The State does not provide reinsurance or stop/loss for MCO/PHPs, but requires MCO/PHPs to purchase such coverage privately. No adjustment was necessary.

B. Incentive/Bonus Payments: This adjustment should be applied if the State elects to provide incentive payments in addition to capitated payments under the waiver program. Antiretrovirals will be carved-out of the capitated reimbursement to eliminate disincentives for encouraging effective use of drug therapies. In order to ensure that total payments to MCO/PHPs do not exceed the UPL, an adjustment has been made to account for expected increases in the number of prescriptions for protease inhibitors (PIs) and non-nucleoside reverse transcriptase inhibitors (NNRTIs).

C. Other Adjustments: Utilization adjustments were made in behavioral health to reflect an expected increase in mental health/substance abuse treatment in some areas.

Comprehensive HIV/AIDS Managed Care Program Exhibit 11 – With-Waiver Costs – Year 1								
	Area 4		Area 7		Area 10		Area 11	
PMPM Component	HIV	AIDS	HIV	AIDS	HIV	AIDS	HIV	AIDS
Capitated Without-Waiver PMPM – Year1	809.99	1400.02	726.95	1297.23	907.44	1758.59	791.90	1984.84
Rx utilization adjustment	7.26%	7.26%	7.26%	7.26%	7.26%	7.26%	7.26%	7.26%
--size & effect	58.81	101.64	52.78	94.18	65.88	127.67	57.49	144.10
Capitated Estimated PMPM Cost (with Rx adjustment) – Yr 1	868.80	1501.66	779.73	1391.41	973.32	1886.26	849.39	2128.94
Percent of UPL Paid	96%	94%	96%	94%	90%	88%	90%	88%
Capitated Estimated PMPM Paid – Year 1	834.05	1411.56	748.54	1307.93	875.99	1659.91	764.45	1873.47
FFS Without-Waiver PMPM – Year 1	58.68	148.89	54.06	137.16	74.15	188.11	117.06	297.00
MH/SA Tx adjustment	6.47%	6.47%	6.47%	6.47%	6.47%	6.47%	6.47%	6.47%
--size & effect	3.80	9.63	3.50	8.87	4.80	12.17	7.57	19.22
FFS Estimated PMPM Cost (with utilization adjustments)-Yr 1	62.48	158.52	57.56	146.03	78.95	200.28	124.63	316.22
With-Waiver PMPM Cost – Yr 1	896.53	1570.08	806.10	1453.96	954.94	1860.19	889.08	2189.69

Comprehensive HIV/AIDS Managed Care Program Exhibit 12 – With-Waiver Costs – Year 2								
	Area 4		Area 7		Area 10		Area 11	
PMPM Component	HIV	AIDS	HIV	AIDS	HIV	AIDS	HIV	AIDS
Capitated Without-Waiver PMPM – Year2	859.15	1485.00	769.77	1373.64	963.70	1826.68	845.75	2119.81
Rx utilization adjustment	3.63%	3.63%	3.63%	3.63%	3.63%	3.63%	3.63%	3.63%
--size & effect	31.19	53.91	27.94	49.86	34.98	66.31	30.70	76.95
Capitated Estimated PMPM Cost (with Rx adjustment) – Yr 2	890.34	1528.91	797.71	1423.50	998.68	1892.99	876.45	2196.76
Percent of UPL Paid	96%	94%	96%	94%	90%	88%	90%	88%
Capitated Estimated PMPM Paid – Year 2	854.73	1446.58	765.80	1338.09	898.81	1665.83	788.81	1933.15
FFS Without-Waiver PMPM – Year 2	60.11	152.52	55.38	140.51	75.96	192.70	119.92	304.25
MH/SA Tx adjustment	6.47%	6.47%	6.47%	6.47%	6.47%	6.47%	6.47%	6.47%
--size & effect	3.89	9.87	3.58	9.09	4.91	12.47	8.03	19.68
FFS Estimated PMPM Cost (with utilization adjustments)-Yr 2	64.00	162.39	58.96	149.60	80.87	205.17	127.95	323.93
With-Waiver PMPM Cost – Yr 2	918.73	1608.97	824.76	1487.69	979.68	1871.00	916.76	2257.08

VI. AGGREGATE COSTS

A. Aggregrate Without-Waiver Costs reflect the estimated PMPM cost multiplied by the anticipated member months to derive estimated total payments.

Comprehensive HIV/AIDS Managed Care Program Exhibit 13 – Aggregate Without-Waiver Costs				
	Waiver Year 1		Waiver Year 2	
Area/Cost Item	HIV	AIDS	HIV	AIDS
Area 4				
Member Months	762	6,229	1,016	8,306
PMPM	868.67	1548.91	919.26	1637.52
Estimated Payments	661,926.54	9,648,160.39	933,968.16	13,601,241.12
Area 7				
Member Months	912	7,455	1,216	9,940
PMPM	781.01	1434.39	825.15	1513.67
Estimated Payments	712,281.12	10,693,377.45	1,003,382.40	15,045,879.80
Area 10				
Member Months	962	7,866	1,283	10,488
PMPM	981.59	1946.70	1039.66	2019.38
Estimated Payments	944,289.58	15,312,742.20	1,333,883.78	21,179,257.44
Area 11				
Member Months	1,975	16,142	2,633	21,523
PMPM	908.96	2281.84	965.67	2424.06
Estimated Payments	1,795,196.00	36,833,461.28	2,542,609.11	52,173,043.38

B. Aggregate With-Waiver Costs reflect the estimated PMPM cost multiplied by the anticipated member months to derive estimated total payments.

Comprehensive HIV/AIDS Managed Care Program Exhibit 14 – Aggregate With-Waiver Costs				
	Waiver Year 1		Waiver Year 2	
Area/Cost Item	HIV	AIDS	HIV	AIDS
Area 4				
Member Months	762	6,229	1,016	8,306
PMPM	896.53	1570.08	918.73	1608.97
Estimated Payments	683,155.86	9,780,028.32	933,429.68	13,364,104.82
Area 7				
Member Months	912	7,455	1,216	9,940
PMPM	806.10	1453.96	824.76	1487.69
Estimated Payments	735,163.20	10,839,271.80	1,002,908.16	14,787,638.60
Area 10				
Member Months	962	7,866	1,283	10,488
PMPM	954.94	1860.19	979.68	1871.00
Estimated Payments	918,652.28	14,632,254.54	1,256,929.44	19,623,048.00
Area 11				
Member Months	1,975	16,142	2,633	21,523
PMPM	889.08	2189.69	916.76	2257.08
Estimated Payments	1,755,933.00	35,345,975.98	2,413,829.08	48,579,132.84

C. Program Costs represent the aggregate estimated total payments both without and with the waiver in effect.

Comprehensive HIV/AIDS Managed Care Program Exhibit 15 – Program Costs and Estimated Savings		
Program Costs by Area	Waiver Year 1	Waiver Year 2
Without-Waiver		
Area 4	$10,310,087	$14,535,209
Area 7	$11,405,659	$16,049,262
Area 10	$16,257,032	$22,513,141
Area 11	$38,628,657	$54,715,652
TOTAL	$76,601,453	$107,813,264
With-Waiver		
Area 4	$10,463,184	$14,297,534
Area 7	$11,574,435	$15,790,547
Area 10	$15,550,907	$20,879,977
Area 11	$37,101,909	$50,992,962
TOTAL	$74,690,435	$101,961,020
Estimated Program Savings	$1,911,000	$5,852,244

D. Administrative Costs reflect anticipated additional administrative costs borne by the State in implementing and operating the waiver program. Costs that would be otherwise incurred in the absence of the waiver are not included.

Comprehensive HIV/AIDS Managed Care Program Exhibit 16 – Administrative Costs		
Cost Category	Waiver Year 1	Waiver Year 2
Actuarial Services	$88,000	-0-
Enrollment Broker	$5,000	$5,000
Independent Assessment	-0-	$100,000
External Quality Review	$52,000	$78,000
MMIS System Enhancements	$45,000	$12,000
State Staffing	$55,000	$55,000
Total Administrative Costs	$245,000	$250,000

E. Cost Effectiveness Summary is the final representation that costs for serving the covered population under this waiver are less than or equal to the costs of serving the same population without the waiver.

Comprehensive HIV/AIDS Managed Care Program Exhibit 17 – Cost Effectiveness Summary			
	Waiver Year 1	Waiver Year 2	Waiver Period
Program Savings	$1,911,000	$5,852,244	$7,763,244
Add. Administrative Costs	$245,000	$250,000	$495,000
Total Projected Savings	$1,666,000	$5,602,244	$7,268,244

The State estimates total projected savings of $7,268,244 over the two-year waiver period (July 1, 2001 through June 30, 2003) to be realized through implementation of specialty prepaid plans under the Comprehensive HIV/AIDS Managed Care Program.